MCH Training Webcast, September 16, 2003

LAURA KAVANAGH: Good morning and good afternoon.
I'm Laura Kavanagh from the Maternal and Child Health Bureau and welcome to this third MCH webcast from the MCH training program.
I'm very happy that you're able to join us this afternoon.
I want to give you a few instructions for the interface that is before you on your computer or being projected in front of you before we continue with our agenda this afternoon, or this morning.
Slides will appear in the central window and should advance automatically before you.
The slide changes are synchronized with the speakers' presentations.
You don't need to do anything to advance the slides.
You may need to adjust the timing of the slide changes to match the audio.
By using the slide control at the top of the messaging window.
We encourage you to ask the speakers questions at any time during the presentation.
Simply type your question in the white message window at the right of the interface, select question for speak from the drop down menu and hit send.

Also because we'll be taking most of the questions at the end of the presentation, you could indicate for whom the question is directed.
We would appreciate that.
Also include your organization so that we know where the question is coming from.
The questions will be relayed onto the speakers periodically throughout this broadcast.
Dr. van Dyck will be taking his questions right after his presentation.
The rest we'll hold until the end.
If we don't have an opportunity to respond to your question during the broadcast we'll respond via email immediately following the broadcast.
Submit questions at that time, they'll be held here and they'll direct them to the proper speaker when we take questions at the end.
On the left of your interface is a video window and you can adjust the volume.
Audio using the volume control slider which you can access by clicking on the loudspeaker icon.

Those of you who selected the accessibility features when you registered, you'll see text captioning underneath the video window before you.
At the end of the broadcast the interface with close automatically and you'll have an opportunity to fill out an online evaluation.
Please take a couple of minutes to do so because it provides vital feedback to us and we use it to prepare our next presentation for you so that we make sure we're developing presentations that are of interest to you.
Now let's move onto our presentations.
First you'll hear from Dr. van Dyck, the administrator for Maternal and Child Health Bureau and then I'll talk about the MCH training program.
It's my pleasure to introduce Dr. van Dyck.
He's the administrateor with the Maternal and Child Health Bureau and very importantly a former Maternal and Child health trainee.

PETER van DYCK: Good afternoon, everybody.
I guess good morning for those of you on the west coast.
It's a pleasure to be here today and have a chance to give you a few words.
They give me the easy stuff.
We leave the hard stuff to the other folks.
I get the easy stuff about talking about a general overview of the bureau.
To give you some grounding in the types of things that we do.
I'll dive -- divide it into three pieces.
Leadership.
Under that comes strategic planning.

The mission in our current strategic plan, and that would be available from Laura and she can perhaps tell you how to get it, for the next five years, that mission is to provide national leadership and to work in partnership is states, communities, public/private partners and families to strengthen the MCH infrastructure to build the knowledge and human resources in order to assure continued improvement in the health, safety and well-being of the MCH population.
And you ask, what is the MCH population?
Well, it's much more broad than just mothers and kids.
The MCH population now includes all of America's women, children, adolescents and their families including women of reproductive age, fathers and children with special health needs.
Think about bioterrorism, genetics or training programs.
Our reach is more than just mothers and children.
On the next slide there are plans and goals in the strategic plan.
And the strategic plan, this last one, the new one for the next five years has a couple new goals.
So if you heard this before, you haven't heard it before.

The first new goal, provide national leadership for maternal and child health by creating a shared vision and goals for MCH.
Informing the public about MCH needs and issues.
Modeling new approaches to strengthen MCH.
Forging strong collaborative partnerships and fostering a respectful environment that supports creativitiy, action and accountability for MCH issues.
The next goal is to eliminate health disparity and health status outcomes through the removal of economic, culture all and social barriers to receiving timely and appropriate healthcare.
The highest quality of care through practice guidance, data monitoring, evaluation tools, utilization of evidence-based research.
The availability of a well trained workforce.

And the last goal to facilitate access to care through the development and improvement of MCH health structure and systems of care to enhance the provision of the necessary coordinated quality healthcare.
Now that's enough about the strategic plan.
Recognize that the strategic plan is derived from these goals.
In the strategic plan are vision statements, further goal statements, enhanced goals, all of the performance measures arrangeed by goal.
It's an interesting document and a very timely document and an important one for you to have some knowledge about.

The second piece I wanted to talk about is performance.
And if we look at the MCH pyramid it's divided into four sections.
This is the way we like to think about the services delivered by the bureau.
At the top of the pyramid are direct healthcare services.
Services we all would recognize, physician's office or health clinic.
Second layer of the pyramid, enabling services, transportation, translation, outreach, respite care, care coordination, case management.
Those things that enhance or enable to ability of folks to get into clinical care or into the healthcare system at all.
The third layer of the pyramid then are population-based services.
Typical examples, newborn screening, lead screening, immunizations.
Sudden infant death counseling.
Nutrition counseling.

All examples of the broad programs that we deliver to population bases, broad population groups.
And at the bottom of the pyramid and at the bottom on purpose we feel it supports the rest of the pyramid our infrastructure of building services.
Needs assessment and training.

Policy development, planning, evaluation, quality assurance, standards, legislation, all of those things which we feel are so important that really facilitate the rest of the healthcare system for community health.
If we look at the arrows on the left we can see a solid arrow that says MCH on it.
MCH is the only federal program and the only state program as well that intentionally provides services at all levels of pyramid.
If you look at a program like community health centers that's what the CHC stands for.

They deliver wonderful direct healthcare services but very few infrastructure services, particularly if you think of infrastructure being statewide or region wide or county wide.
If you look at the right-hand side of the pyramid there are a couple of dotted lands around the Medicare and other programs.
They deliver direct care services although spotty at times.
Certainly they don't build infrastructure and healthcare service.
So that is rather a fairly short explanation of what MCH does but helps to put it into context for everybody so we know we're all talking about the same thing.
The last major area is accountability.
And there is a very busy slide I'm going to show you which is the performance measurement system.
But again it's an overall encompassing slide and is a way to help explain, demonstrate, represent, kind of how we think, how we use the strategic plan, how we use that pyramid in putting in writing, basically, putting on paper some schematic for what we do.

You look at the left-hand side of that slide, we look at needs assessment or health status indicators and whether you're in a state or university, training program or at the federal level we all have to do needs assessment.
And we all look at national and state priorities or indicators or Healthy People 2010 indicators or check with our partners.
Somehow we assess what are the needs related to our own domain of interest?
Once we do a needs assessment we move to the next column.
The MCHB priorities and goals.
And there are three as an example here.
I read four or five at the beginning of my talk.
Decrease disparities, increase equality, improve infrastructure, provide national leadership.
These are a set of MCHB priorities and there are more in the strategic plan.
But these follow from the needs assessment.

They represent what are the findings of the needs assessment and in the same way as we move to the next column, how do we activate?
How do we put meat on the structure of these priorities and goals?
What is our program, what is our resource allocation?
That is drawn in the shape of a pyramid because I've just described direct health, population based infrastructure.
We actually think what resources are we going to put towards direct services or do we need to put more towards infrastructure or population-based services?
This is an active dialogue that we undergo.
And so we activate these priorities and goals through at the bureau level, request for proposals or contracts or special other programs.
And you do in the university by who you hire, what trainees you accept, what grants you apply for.
Then we move on to more evaluation.
How do we have a feeling for what we're doing being successful or not?
That's where the performance measures come in.
You're acquainted with our performance measures.
If you aren't, you will be shortly.
Performance measures help measure how well we're implementing some of our strategic goal plans through our resource allocation and program measures.

We have performance measures for the state block grant program and performance measures for our other discretionary grant programs.
That's our attempt to measure success.
Then we hope that all these efforts will affect outcomes.
We list and keep track at a minimum of these six outcomes and often more, child mortality and infant death disparity between African-Americans and whites.
If those outcome measures don't decrease, or don't improve, then we need to re-evaluate, we need to reassess and circle back around, relook at the needs assessment, relook at health status indicators and re-evaluate where we are and start the cycle again.
This is a method you can use as you look through your program efforts.
But it also helps you understand, we ask you for things, how it fits into our structure.

The next slide we're going to talk about the budget to give you a quick feeling about the budget of the bureau.
What we have demonstrated on the slide is the fiscal year 2003 budget, the year we're currently in.
And the president's budget for fiscal year 2004.
The Senate and house are currently marking up the 2004 budget.
Hopefully we'll have a budget by October or November.
This is the president's budget.
$730 million for the block grant this year in the president's budget $750 million.
The state block grant is that part of the block grant that goes to states for the state MCH programs and there is an increase from $600 million to $622 or so.

The special projects, regional and national significance, most of the training programs are funded from that category has a modest increase to $109 million.
The kiss program has a modest increase as you can see.
And there will be ear marks.
These are programs Congress wants funded.
They give us one year specific funding to fund say a genetics program or an autism program, or a special training ear mark or sickle cell program and so we add those up.
They don't show in the president's budget because they go to Congress.
We'll get another several million dollars earmarked this year.

Not in Title V legislation or not in the MCH legislation per se.
Most of these are in the public health service act.
Programs nevertheless run by the bureau, run by experts here at the bureau and carried out at the local level by communities, states, hospitals, universities, and others.
The healthy start program, a program to combat infant mortality in high-risk cities.
Hearing screening program.
A program that is trying to assure hearing screening for every newborn in the country.
We're making good progress in that program.
You can see on the slide it zeroed out for 2004.
The president has suggested that that 9.9 million dollars, wants the activity to continue but wants us to absorb it within the block grant to the states program.
EMC is the emergency medical services for children program.

When you have to call an ambulance for a baby or an infant or a child in your community, you want those people trained on how to take care of that child regardless of age and to have the right equipment and know how to use the right equipment depending on whether that infant or 17-year-old or 15-year-old child.
That program is geared to that.
Poison control centers across the country are shored up by the Maternal and Child Health Bureau.
Trauma, emergency medical services system program.
The abstinence education program are run by the bureau.

Bioterrorism program is a huge program to try to bring readiness to hospitals across each state to be able to combat a bioterrorism or other natural or non-natural event.
And the last is the traumatic brain injury program, a program geared towards improving the health and the long term outcomes of children and adults from traumatic brain injury.

I hope that gives you an idea of the breadth of the programs in the bureau and a little bit about the way we conduct business and an overview that will help you understand some of the other discretions you hear today.
I have a last slide that small a small advance every day will total much less than a big advance each day.
Why waste time making a small advance every day?
Do a big advance every day.
It's wonderful to talk to you and have a great afternoon.
I'll be happy to answer questions if you type them up on your computer and I'll turn it back to Laura.

LAURA KAVANAGH: We'll pause here to give you an opportunity to type in any questions that you have for Dr. van Dyck.
If you don't think of one immediately we also can take it later in the presentation.
His office is right behind that door.
He said he would be willing to have us interrupt him later on as well.
Do we have any questions at this point?
Not right now.
Thank you very much.
All right.
Please, if you have a question that come up as well, please add them -- you can add them to your screen as well any time throughout the presentation.
Thank you very much to Dr. van Dyck.
He gave a wonderful overview of the bureau.
I'll now turn us to the MCH training program.

You're affiliated in one way or another most likely with the training program as a faculty member, trainee or former trainee.
We're fortunate to have several former trainees who are presenting with us this morning as well.
I want to give you an overview of the big picture of the training program.
I'm learning this as well.
Starts with the president, who is the boss of secretary Thompson who is the head of the Department of Health and Human Services.
Within the Department of Health and Human Services is the health resources and services administration which is the agency in which the Maternal and Child Health Bureau sits.
And then Dr. van Dyck is the head of the Maternal and Child Health Bureau.
So that's the big picture of where the Maternal and Child Health Bureau sits within the federal agencies.

The next slide Dr. van Dyck reviewed the MCH pyramid which is a way we use to describe the types of services supported by the Maternal and Child Health Bureau and as he mentioned, the training program is at the base of the pyramid as part of the infrastructure building services that are vital to supporting all of MCH services.
Now I would like to give a little bit of context of the funding for the MCH training program.
Dr. van Dyck mentioned the Title V program and an important aspect of the Title V program special projects of regional and national significance.
The training program comprises about 35% of the investments in special projects within the bureau.
It is a significant investment here.
Also MCH triangle helps to explain some of the services that are supported by the Maternal and Child Health Bureau.

As you see at the base of the pyramid -- triangle are research and training and services and policies at the top.

It's an unusual federal program in that it has demonstration grants, applied research investments and the MCH training program in one agency.
We hope that by doing this we learn from one another that what is learned in the field through demonstration programs can be implemented in training programs or further research can be quickly implemented in demonstration programs and also included into training programs.
Now I would like to move one level organizationally to the Division of research training and education.
It houses the training branch.
The next slide you'll see Dr. ANDROM is the director of that department.

Chris DeGraw is the deputy director of the division and within the division are the training branch which houses our program and the research program.
What are the goals of the training program?
We're in the midst of a strategic planning process for the training program.
And there are six goals that have emerged as continuing goals for the MCH training program.
First and foremost to develop a workforce with the knowledge, skills and attitudes to meet unique MCH population needs.
Other agencies support training but none of them focus on the special needs of Maternal and Child health populations exclusively.
We want to support a diverse workforce that is family centered.
I'll talk more about that in just a moment.
And we want to develop effective MCH leaders.

We have a particular emphasis on leadership training and very high expectations of our trainees that they'll not only become wonderful administrators and wonderful clinicians but they'll be change agents that they will advocate for services for mothers and children within their communities, regionals state and nationally.
We've seen that through evaluations we've conducted that former trainees have done some marvelous, marvelous things.
A fourth goal is to generate, translate and apply new knowledge that connects between training and research.
We emphasize is here.
That's part of the reason why research and training are housed within the same division.
We want to emphasize that also within the training program.
We want to develop national support for and investment in MCH training.

I was struck as we were developing this strategic plan at the number of agencies, including the Institute of Medicine, variety of foundations and some state health departments that have been doing some strategic planning around healthcare workforce issues, how many of them emphasize many of the themes that are important to us.
Interdisciplinary training.
Leadership training.
A emphasis on the Maternal and Child health population.
Very few of these foundations were investing in the training to make these outcomes occur.
We want to advance interdisciplinary training and practice.
Another unique investment that we're making.
One of the few federal agencies or any agency that is focusing on interdisciplinary training.
So when we say we're training for leadership, what does that entail?
It starts with recruitment.
It starts with picking folks who we think will become leaders in the field.

It's a training program that you're a part of, spend a lot of time thinking about these issues of who they will recruit.
How will they reach out to new fellows, new trainees in the coming year or future years.
And then they begin a process within the curriculum of skill development.
This takes on a variety of different tasks.

Includes clinical skills, research skills, organizational skills, and advocacy skills.
We want everyone to be wonderful, like I said before, administrator or clinicians but to have wonderful communications skills and advocacy skills to allow trainees to become leaders.
MCH values and approaches are important.
Cultural confidence.

Community based care are important values that we want to instill in training as well.
Through an evaluation that was conducted of the MCH training program several years ago these were examples of the leadership activities of former trainees.
I learned more about them from a new group of trainees every year.
It includes offering book chapters and journal articles.
Publishing original research, teaching, developing their own curriculum.
Starting a new fellowship program and developmental behavior pediatrics.
A child abuse team.
Working on advisory groups at various level both local and nationally on child advocacy activities.
You're among a group of folks who are making a tremendous difference in the field of Maternal and Child health.
Let me give you a snapshot of the MCH training program.
A profile.
Our annual budget is $36.7 million.
I
ncreased some over the course of the last several years.
We've been very fortunate.
As Dr. van Dyck mentioned we expect a slight increase in Title V.
We hope the Senate and house will increase the funding as well.
We support 11 categories of interdisciplinary training.
Of long term training, rather.
Some of those are interdisciplinary and some are single disciplines.
They include leadership education in neurodevelopmental disabilities.
Schools of public health, adolescent health, pediatric pulmonary centers and public health certificate program.
We support programs in developmental disorders.
Social work, nursing and pediatric dentistry.
We support continuing education to reach out to those who are already practicing in the field.

And we have small continuing education grants about $30,000 a year.
Distance learning grants.
MCH institute and graduate medical education.
This year for those of you who might be writing grant applications in the coming year, the lend -- one cohort of the lend program.
The certificate program, continuing education and distance learning will all be completed in the coming year.
If you want to get additional information it's available on the HRSA website at WWW.HRSA.gov and it lists all the activities that will be funded in the coming year for that administration.
The next slide talks about our supported trainees and faculty members.
This is an understatement.
What I have confidence in this data because the grantees are reporting who they used MCH training grants to help support.
We had 727 supported trainees in fiscal year 2002, 557 at the pre-doctoral level and 170 at the post doctoral level.
There are many other post-dock and pre-dock students who get the same course work from faculty but may not get the MCH.

They were supported faculty and 65 full time equivalents who gave time in kind for the program.

It's a significant investment on the part of the universities as well who are allowing faculty to spend time on the grant without being compensated.
The next slide shows an allocation of the training program resources among the different priorities.
You'll see that about half of the investment currently supports leadership education and neurodevelopmental disabilities or the lend program and the interdisciplinary programs are the next largest groups.
Schools of public health, adolescent health program.
Pediatric pulmonary centers and distance learning next.
The others average between 3%, 2% and 1%.

On the next slide is a map of the training grants.
You'll see they're pretty well dispersed in the United States.
The point I want to make is there is already a network of students and faculty participating in the program that I hope you will seek out because they're having experiences that are very similar to yours and when you complete your training experience that network will continue to exist and I hope you will link up in another program as a faculty member or start your own program in the future.
I would like to briefly review some of the training priorities that we have for the next year.
As I mentioned earlier in the midst of the strategic planning process.

We developed the goals, the objectives are underway and you'll be hearing more about that in the fall and winter of this year.
We also carefully examining this concept of leadership.
We've been using the term for some time saying this is a leadership training program.
What exactly do we mean by that?
What are indicators of leadership?
How do we measure our success in this area?
We want to do a better job of measuring our job so we can communicate that to our colleagues, communicate it to training programs and to Congress and others.
We'll also be working with a contractor at the University of Florida to develop a training website so we'll have one central area where you can send curricula.
Make announcements about webcasts such as this.
A one stop shopping for training resources in Maternal and Child health.

Culture all competency continues to be a priority for us.
We're getting training for our own staff here within the Maternal and Child Health Bureau and continue to strongly encourage you to include that within your training program.
The others remain a priority.
The grant programs you'll be hearing more from me about that in the near future.
We hope in the coming year you'll be sharing data on those performance measures with us.
And the performance measures are on the next two slides.
There are four that are now Office of management and budget approved.
The first one is the percentage of graduates of long term training programs that demonstrate field leadership after graduation and we've tried to provide a definition of what we mean by field leadership.
It's broadly defined from a cultural, linguistic and geography end point.

The third one is the degree to which MCH supported programs ensure family participation in all their activities.
There is a scale that programs will rate themselves on and the fourth is do long term training grantees to include cultural competency in their curriculum and training.
They'll be submitting data on their performance measures to us.
Last, I hope to get to meet you in person and not only virtually.
Please stay in touch.
I'm readily accessible except for the next several days because we're in the midst of a move here at lkavanagh@hrsa.gov.
Please respond to the surveys so we know where you are five or ten years from now.

We're going to hold questions until the end of the sessions but if you do have any questions for me, please type them in now.
Note that they're for me and I'll be happy to answer them at the very end.

MADHAVI REDDY: I think we have two questions for Dr. van Dyck.

LAURA KAVANAGH: Two for Dr. van Dyck.
Let's see if we can ask him to come back.
We're going to pan out to an empty chair for a moment.
Dr. van Dyck will be joining us to answer some questions.
We took you up on your offer.

>> We have the first question, what happened to trauma and EMS as well as hearing screening?
Were they completely scrapped out for fiscal year 2004 or have they been absorbed under other divisions?

PETER van DYCK: When I showed the slide of the budgets, newborn hearing screening had a zero under the president's budget and so did EMS trauma.
I guess it just had a bad accident.
What happened was the same thing.
The president, the administration, wanted the program carried on but thought it could be absorbed within the Maternal and Child Health Bureau block grant and states program.
In both the mark-up's in the Senate and house for 2004 the Congress restored money to both of those programs in the markups.
That doesn't mean it will be there in the final but that's what's happened so far.

>> The second question with the $20 million increase in abstinence education programs, simultaneously with the decrease in hearing screenings, trauma and other programs how will it affect our communities and families?

PETER van DYCK: The proposed increase to $73 million for abstinence community program will obviously no doubt increase the ability of communities to provide abstinence education for those communities and there will be an additional 30 grants or so to communities.
If, as we expect, we will receive money from Congress for the newborn hearing screening and trauma programs, we don't expect a change in the activity level in those programs.

LAURA KAVANAGH: Thank you very much.

PETER van DYCK: Thanks for asking.

LAURA KAVANAGH: Again, you can type in questions on the interface and we'll be happy to answer them later on in the broadcast.
We have a very rich program for you today.
We want to make sure we get to all of our presenters as well.
In an attempt to vary the content of our MCH training program WebCasts we've invited some former trainees and faculty members to present the research they've conducted in the area of health disparities and cultural competencies.
You'll hear from presenters of the University of Rochester leadership education in adolescent health program and the University of Illinois in Chicago leadership education in Maternal and Child health program.
First to present is Cheryl Kodjo.

Senior instructor at the University of Rochester.
She was a leadership education in adolescent help fell free from 1998 in 2001 in the Department of pediatrics.
She'll present the career development of a Rochester MCH fellow.

It encompasses themes throughout her medical training.
Her recent research efforts in mental health service utilization and future opportunities in medical education regarding cultural competence.
Welcome Dr. Kodjo.

CHERYL KODJO: Good afternoon and good morning to you.
I'm very happy to be here.
For the outline of my talk, I would like to first talk about where I've been so far and my career trajectory.
I would also like to review some of the research studies that I've done as well as some upcoming research that I have planned.
I would also like to talk about future directions that I'm planning for my research, as well as some other activities that I've had the benefit of participating in as a result of conversations about my research.

So as far as my career trajectory, this is a very unique opportunity for me to just kind of reflect on where I've been and where I'm going.
And so when I look back, I think things for me started with my residency training at Albert Einstein college of medicine and I was involved in a special program called social pediatrics.
Its emphasis was in community medicine.
When I was doing my residency, my clinical practice was based at one of the community-based health centers on 161st street.
I got plenty of experience working with underserved populations.
The other benefit of being in the social pediatrics program that's where I got my first grounding in the social model.

When I was taking care of patients, being able to incorporate what their social context was into their care was something that I was first able to learn at Albert Einstein.
When I decided to do an adolescent medicine fellowship in 1997-1998 I was very excited about the idea of going to Rochester.
One reason being that I knew that the theoretical framework that I had already had some grounding in, the biopsycho social model was something that would be continued with me going to the University of Rochester.
They have a long history of advocating for and teaching the biopsycho social model to their students.
The other thing I was very excited about was the possibility of being able to participate in the MCHLEA program.
That was a very unique opportunity I had the chance to work with people from different disciplines and different percent -- perspectives.

We were able to collaborate on patient care and research topics.
The other benefit I was able to gain by participating in that program was to get mentorship from Dr. Ryan who will be presenting to you after myself today, but we were able to initiate some projects specifically as it pertained to youth violence and I was able to build up research skills.
I was very fortunate over the course of the rest of my fellowship to be able to get funding support to continue some of those initial research efforts that Dr. Ryan and I started working on.
I particularly was able to follow through on things with a fellowship award that I was able to get for the second and third years of my fellowship.

And then over the course of the time that I have now been a
faculty member since July of 2001, I've been able to have some other funding supports that have allowed me to further develop my interest in mental service utilization as it pertains to racial and ethnic disparities and specifically to acknowledge the ambulatory pediatric association, the hager tea Friedman scholars programs and a small grant program which I'll allude to over the next couple of slides.
So I would like to use the next three slides to talk about some of the research projects that I've done or am in the process of completing.
Other things that I have planned for this upcoming year.

The APA award that I got was able to allow me to purchase the national longitudinal study about adolescent health and I was able to do an analysis of that data.

I shifted gears as far as being interested in youth violence and moving more towards mental health service utilization partially because the two issues are connected as far as engaging in youth violence and the mental health of youth.
But also secondary to what I was seeing clinically it was just an area of interest that arose.
So when I had the secondary database the objective I had was to determine the cause for receiving psychological counseling.
What we found was that even for the subset of kids who were most emotionally distressed, the majority of them did not receive counseling.
And then when we looked at things along racial and ethnic lines we found that black adolescents were less likely to receive counseling.

That was statistically significant and we found that Hispanic adolescents of foreign born parents were less likely to receive counseling, although this did not reach statistical significance.
These findings, as far as race ethnicity were after us controlling for household income, insurance and other sorts of SOCIO demographic factors.
With this first study we were able to see that there were racial and ethnic disparities in mental health utilization as well.
And clearly this has implications for the mental health outcomes of youth of color.
It was good that I could start with the secondary database.
But it had its limitations in terms of not being able to ask the questions that I wanted to ask, but also not allowing a more in depth analysis of how or why minority adolescents don't use mental health services.

And so we feel that research focusing on how it is that minority adolescents perceive and utilize mental health services is still needed.
So secondary to that study I've been able to come up with some other field studies.
The first one being a survey and interview study that we did of 58 adolescents we were able to recruit from our hospital-based practices.
It was a convenient sample.
What we wanted to determine was adolescent attitudes about mental health services.

The results that we found were that adolescents were right on the mark as far as being able to identify depressive symptoms, being able to identify symptoms severe enough to warrant mental health services, although they could say that it was embarrassing or didn't want their friends to know or wanted it to seem as if they were handling things as barriers for them actually getting engaged in mental health services.
Some of the data also interestingly alluded to there being some racial and ethnic differences in perceptions of health and provider preference.
So specifically when we asked kids about their definitions about health, many kids said things like being clean, being physically fit, having good nutrition.

We had one particular respondent who said being able to survive.
This was a 17-year-old African-American female.
Then when we looked at provider preference, more than half of our African-American adolescents reported that they would refer to have an African-American counselor saying that black counselors can understand black problems.
So with that first field study it was great because the kids were willing to participate and I thought they were very honest in their responses.
But it was a skewed population in the sense that it was hospital based.
Many of our participants were white females.
There wasn't much variation in terms of SOCIO economic status.
The next step is we would like to recruit a more diverse population to ask the same questions.
And fortunately through the SCRC.

Strong children's research award I'll be able this year to collaborate with the Rochester city school district.
That is a school district that is predominantly African-American, about 60% African-American, and about 20% Latino.
So I'll be able to get at some of the racial and ethnic diversity that I would like to study further.
So our objective is the same as it was with the previous study, being able to determine adolescents' attitudes about mental health services.
For this particular study we're planning on putting an emphasis on the quantitative data that we'll be able to elicit from these students.

But we're expecting that we'll be able to better understand why it is that minority adolescents who need mental health services, don't actually utilize or engage in them.
So I think at this point being able to get some of the preliminary data I've gotten so far, even some of the data that I'm going to be collecting this year puts me in a position to really start to look at how are we going to make program changes as far as mental health services are concerned?
And I think I'm at a point now where I need to consider doing intervention and evaluation studies based on what the adolescents tell me they want for their services.
So I'm now at the point where I need to think about further funding.

So the idea is being able to get a career development award from the Robert Johnson foundation or from the N.I.H. are things I'll be exploring over the next couple of months.
The other thing that I'm very interested in, I've had the benefit now throughout my training and throughout me being a junior faculty member to work with kids one-on-one.
And as I'm gaining more expertise in this particular area of interest, I very much would like to take on more of a role when it comes to talking about populations of adolescents.
So being more involved in health policy and advocacy is something that I'm seriously considering in the venue of specific training.
And then finally with talking about my research with colleagues, the research has kind of led to other opportunities that I've been very excited about.

One of them being that as we talk about these racial and ethnic disparities as it pertains to mental health service utilization, issues that have come up are issues of cultural competency and culture all effectiveness of the healthcare system.
How are we going to train people to have the skills to work with diverse populations, as well as how are we going to seek recruit, train and maintain minority faculty and minor at the residents?
And so I am now part of an initiative with the Department of pediatrics to be able to look at what we're doing as far as minor at the health staff recruitment.
This involves several tiers of intervention including revising recruitment materials that we've had, developing support networks for minority house staff, with the idea that if we can retain these trainees that they could eventually move on into academic positions.

And also to coordinate cultural competence didactic series because they all need to be culturally competent.
We have diverse populations in Rochester that need to be served.
Finally something else that I'm very excited about, this is kind of getting me back to my roots in social pediatrics, is the idea of being able to collaborate with an urban community health center to provide Adolescent Health Services that are interdisciplinary.
I would like very much for our trainees to be involved.
As well as being able to provide culturally competent services as well.
That's something that we're working on for the next year as well.
So I thank you very much for your time and at the end of our session would be more than happy to answer any questions.
Thank you.

LAURA KAVANAGH: Thank you very much.

Our next presenter is a colleague and mentor to Dr. Kodjo at the University of Rochester.
Sheryl Ryan, M.D. is the training director at the University of Rochester, associate professor in the Department of pediatrics.
She'll present the northeast Rochester youth and family wellness project, providing health education in community settings.
The focus of the project is to provide health education services to middle school adolescent populations with diminished access and enormous disparities in health indicators in the City of Rochester.
In the areas of violence prevention and healthy lifestyles.
Welcome Dr. Ryan.

SHERYL RYAN: Good afternoon and good morning.
I would like to thank Dr. van Dyck, Laura for inviting us to come to Rochester to speak with you and giving me the opportunity to talk about this project.
I would like to provide some object tivs of what I'm going to be speaking about today.
First I'm going to give a brief background of my professional development to give you an idea what brought me here today.
And then I'm going to provide background on the rational for the service demonstration project.
Then I'm going to describe the methodology of this project for providing health education services to youth in community settings and address some of the challenges we face in providing this program.
Finally, I would like to talk about sort of our data that we have, both our tests and post-test data and talk about some of the initiatives or follow up.
The next steps that we are considering taking in terms of this project.

In terms of my professional background, I clearly wouldn't be able to do what I'm able to do today were it not for the training that I received as a fellow at UCSF in the LEA program and the mentors that I was fortunate enough to work with during those -- during my training program.
My faculty experience has also helped me to refine my interests and I have found this is similar to what Dr. Kodjo was mentioned in terms of moving from research into intervening.
I found that over the time of my time that I spent at the University of Maryland in another LEA program at the time to here at the University of Rochester where I am currently, I found that my interest has moved from looking at high risk behaviors and looking at studying health services, to actually having the opportunities to intervene in order to prevent high risk behaviors and to look at actually providing types of services that young people have not traditionally had access to.
Before I discuss my project, I would like to acknowledge the contribution of both my colleagues, the many colleagues who have worked with me on this project and also like to acknowledge my funding sources.
The Maternal and Child Health Bureau, AAP, healthy tomorrow's, partnership for children project.
Funding as well as LEA.
I wear a couple of hats.

Both as LEA training director as well as a recipient of the healthy tomorrows project.
The Rochester community, the population where I chose to locate my project is located in a quadrant of the City of Rochester that has been described by most recently by the mayor as being part of a fatal crescent, which spans from the northeast part of Rochester to the southwest that is described as being ravaged by crime, poverty and drug problems.
The population in this area, particularly the youth, have some of the worst health indicators in this area.
And there are high rates -- high numbers of the population, it is estimated that 40% of the population dips below the federal poverty level and 65% are from minority backgrounds.
Primarily African-American and Hispanic.
There is a close relationship between these rates and those among the poverty.
Further, we know that there are high homicide rates that have been reported in this area.

The youth risk behavior statistics in the high school youth area report high rates of weapon carrying and physical fighting.

We also know that there are pronounced disparities in these compared with other parts of the city, other aspects of the Monroe county community where Rochester is located, as well as New York state.
And the population in this area has limited access to healthcare as well as virtually no access to comprehensive health education programs.
The overall goal of my project was to improve health behaviors in three areas, violence and aggression, sexual risk, and lifestyles such as exercise and nutrition.
By providing health education programs to adolescents in community settings.
Specifically we were hoping to improve knowledge, skills, attitudes, intentions and behaviors in each of these three areas.
In our population were middle school youth and families in community-based settings.

We chose to locate our programs in community settings to go beyond the schools in order to reach families who were perhaps using services at agencies that they were more comfortable using rather than locating them at schools where families might not feel as comfortable, not as familiar with.
In terms of our methodology, our initial task was identifying and developing collaborations with community-based agencies who provided the services to youth and their families.
We started out with six agencies located in northeast Rochester and at the end of our five years we are now in more than 25 agencies throughout northeast and some in greater Rochester.
We provided programs in the three curriculums, the middle school youth and their families with a strong evaluation component and I will discuss these curriculums further in a moment.
And one of the other first things that we did as part of our project is convene a project advisory team.

Are representing broad segments of the northeast Rochester community so we could get a good idea from the community themselves what it was that they felt that they needed in terms of health education to make sure that we were on -- we were basically on track with what we felt the needs were to make sure that this is really what the community wanted and felt that they needed in terms of services to youth.
The three curriculums as I mentioned are in the areas of violence prevention, sexual risk and healthy lifestyles.
Violence prevention curriculum we used the second step program which is out of the Seattle committee for children's group and is a very skills-based program that emphasizes skills in the areas of empathy, problem solving and anger management.

The sexual risk project was the program was the Rochester aids prevention program, the rap for youth program developed at the University of Rochester, and for a healthy lifestyles we adopted a program developed at Rochester general.
Used components from the heart power as well as the Department of Agriculture has several curricula that we adapted.
All of these programs were highly interactive.
Involved skills-based sessions.
Most of the programs, each of the programs ran anywhere from between 12 to 15 weeks lasting for about an hour.
And we provided them to groups of adolescents.
Around 12 to 15 adolescents.

The programs were run by teams of health educators and initially were run by just the health educators and later we added a group of peer educators mainly because we had a group of teenagers who went through all of our programs, refused to graduate from our programs and said what more do you have to provide and we developed an additional youth leadership curriculum that involves training peer educators and we brought them into the programs with us which has been probably one of our most effective programs that we've done.
All of these programs, as I mentioned, were based in community agencies and we piggybacked onto programs that were already being run in the agencies where there was groups of adolescents that had already been formed that were involved in recreation in those programs.

We also offered special workshops for parents as part of each of the programs.

In terms of our evaluation, we -- all of the youth completed a pre-test survey and a post-test survey.
For those we were able to identify and contact, a one year follow up survey measuring overall knowledge, skills-based knowledge, attitudes, intentions, self-he have cast see and reported behaviors of both their parents as well as behaviors of their own.
All three behaviors.
Because all of the youth received questions on all of the different three areas, the group was able to service and control the other group.

We also did mid-point and end-point process evaluations just to get a sense of whether the kids liked the programs, what they liked best, what they didn't like so that if there were some key things that we found we were doing well or not doing well we would be able to change things and keep on track with improvements.
So in the past five years of our funding we've been -- we have provided services to approximately 325 youth.
You can see that 60% of our programs were in the area of violence and that is secondary to the demand by the specific agencies for this particular program.
Compared to the others.
The range is right there in our middle school.
The mean is right there in our middle school, 13 years.

Although we did have a very wide range that reflects the fact that these are open programs and if we had a younger sibling or an older sibling who the agency wanted us to provide services to, we tended to be more responsive to their needs than just -- kept it more fluid and had ages younger and older than our initially targeted middle school youth.
The race and ethnic background of a population really is like the population of northeast Rochester.
Predominantly African-American with, again, larger groups of both biracial and Latino youth.
Our pre-test results confirmed that there were huge opportunities for improved behavior as you can see in this slide.
All of these three target areas.
28% of our youth reported that they carried a weapon in the previous year.
65% involved in physical fights.
75% of the males reported that they had had a history of sexual intercourse and 26% of the females.
And 80% of our youth reported that they ate one or less vegetable in the previous day.

We recognized that we had huge opportunities to improve behavior in the areas we were ear marking.
In terms of our process evaluation, overall our adolescents reported that they liked the programs very highly.
They disliked the fact that our programs were too short.
Wanted them to continue beyond the 15 weeks and what they liked best was the opportunity to be able to talk about what is really affecting them.
Being able to talk about what our experiences really are.
They said for many of these young people this is one of the first opportunities they had had to really talk to someone and get their questions answered in the specific informational ways.
The project advisory committee was also very, very helpful and really has had a critical role throughout the whole course of this project.

As I mentioned, we have representatives from broad sectors including parents, teens, the faith community, the business community, the public health community and they have been very interested in our programs, how they're being implemented, as well as the data that we've obtained both pre-test, post-test and vocal in giving us information or ideas to keep on track and how to remain basically in connection with the community.
We do have some preliminary post-test data that are showing some encouraging findings and in terms of our violence prevention, our pre-test, post-test results show that our young people have demonstrated improved attitudes, intentions and skills knowledge.
Those are skills knowledge in the areas of mentioned.

Anger management.
The sexual risk has demonstrated improved knowledge and attitudes.
Unfortunately not with intentions.
And our healthy lifestyles has demonstrated improved intentions and attitudes.

All of these programs for all of our programs, the pre-test knowledge and the percent attendance in the programs is the strongest predictor.
It wasn't just the fact that they were in the intervention, just the number of sessions they went to which is encouraging.
We think that to attend more sessions the young people will get more of the information.
We're in the process of completing our one-year follow up and at that point hopefully we will have the specific information on behavior changes that have happened over the course of the year as well as whether the changes in knowledge and attitudes are maintained.
This project is not without its challenges.
And I would like to just discuss a few of these.
The first one for us was really to build meaningful collaborations with the community-based organizations.

It was clear that there are different cultures between the academic world, the health center world and the world of health services agencies or agencies reaching out to families and youth.
We realized there was a huge need on our part for sensitivity to the issues of the community and the agencies and that our acceptability was a slow process.
It took time and energy and required a lot of persistence on our part.
But I think we feel that at this point we're well accepted by the community and have actually received a number of community service awards.
Our project has specifically.

We also recognized and the advisory committee was very -- was continually reinforcing this, that the cultural competence of our health educators and evaluateors was critical and we saw very carefully to find health educators who were from the community.
If not from the community, at least had experience working with the community, working with young people.
We found that these people were much more effective than someone who might have had an advanced degree in health education but had no experience working with the community or working with youth.
We also recognize that involving family consistently in our case was almost impossible.
And we found that although families are very interested in the content, were very interested in having the young people participate, there was just really not enough time for many of these families to come to the workshops working two jobs, having several other children, many of them being disabled and having issues with transportation and health.
So that, I think, for us, a challenge is to try to get -- to include families and the project advisory committee has been working on this.

Our next steps are to utilize the wonderful collaborative ties that we've developed in order to further the communities to address the health issues facing the communities.
Recognizing that we need to be responsive to the needs of the community and we hope to be able to provide services.
We also recognize that what we do on the projects is our roles have changed somewhat in that we now are not being sought just to provide services but we are being increasingly sought out by community agencies to provide training and to provide technical assistance in similar curriculas that many of these agencies are choosing to provide on their own.

We're also looking at the possibility of expanding our presence in specific community settings that up to now we have not been traditionally involved, such as school settings.
Schools are coming to us wanting us to work in their health education programs as well as some of their after-school programs.

More rural settings.
We've been contacted by a number of counties outside of Monroe to look at more rural settings who are dealing with some of the same problems that the northeast Rochester is and we're also looking at expanding into the juvenile justice centers.
I want to thank you for allowing me to describe this program and again I'd be happy to take any questions at the end should you have any.
Thank you.

LAURA KAVANAGH: Thank you very much.
Please, if you have any questions go ahead and type them into your interface and we'll answer them at the end of the next presentations at the University of Illinois Chicago.
Our final presenters will be Michelle Kelly.
Swapna Sawardekar and Jeanne Concha from the University of Illinois, Chicago School of Public Health.
Dr. Kelly is an associate professor in the Division of community health sciences and a faculty member in the leadership education and MCH program.
She's accompanied by Dr. Sawardejar and Ms. concha, trainees in the division.

Dr. SawardeKar is an MPH student in the leadership education in Maternal and Child health program and Ms. Concha is a Ph.D. students.
Both students work with Dr. Kelly as research assistants in a social capital project.
They'll present HIV part -- A collaborative case study was conducted on the meaning in a community driven, federally funded HIV prevention and control program in a Chicago Puerto Rican community.
To identify the community context and processes by which social capital is developed and employed to address community health issues, specifically HIV.
Preliminary findings on the community conditions that foster development and growth of social capital will be discussed.
The role of the community based organization as a vehicle for implying knowledge of the concept to community problems will also be described.
Finally a broader application of social capital for designing local approaches to reduce health disparities is considered.
Please join me in welcoming Dr. Kelly, Dr. Sawardekar and Ms. Concha.

MICHELE KELLEY: I'm Michele Kelly.
Greetings to friends, students and colleagues here at UIC at the University of Puerto Rico and at Johns Hopkins where I was a former MCH trainee.
You'll be hearing about this wonderful community we have the opportunity to collaborate with and I also want to thank them first off.
Say more later.
They are aware of our presentation today and fully endorsed it as we are, in fact, talking about them and presenting their data.
Also want to thank the bureau for this opportunity.
This study was part of a multi-site collaborative with the University of New Mexico, tue lane university and St. Louis university.

We want to acknowledge people at UIC as co-investigators on this project.
I'm also very pleased to be Swapna and Jeanne with me today.
They joined the study in the analysis phase.
They're knowledgeable about the community and have contributed greatly to the ideas presented here.
Because of time constraints, we won't read every slide aloud but will comment on them instead.
You can follow along.
The project goal.
Social capital is considered as potentially important for designing collaborative community based solutions to reduce health disparities.

In the third objective we see that we have much to learn from the pros tech tors and resources that communities have developed about their specific health issues.
We never start from scratch, so to speak, when designing interventions.
We start with an understanding of these processes and assets in the community and work to enhance them at the direction of the community.
When I approached the community about the project, I was concerned about their reaction to this term social capital but to my surprise, the leadership was very familiar with the concept and so I've captured their reaction with the quotes above.
It is clear that we public health practitioners and scientists are the ones that need to learn about this concept and it is a social protective factor from the community.
So what is social capital?

There is a lot of literature relating social capital to community-based health promotions.
A doctor offers a brief definition.
Those -- you can see it on the slide.
Those specific processes among people and organizations working collaboratively and in an atmosphere of trust that lead to accomplishing a goal of mutual social benefit.
Now, the full references will be at the end of these slides.
Dr. cueter retired from CDC and known for his expertise in community based health promotions.
Under his leadership along with Diane Rowley, who many may know.
This multi-site research initiative was development.
Social capital and community capacity are regarded as social protective factors.

They're necessary for program design, implementation and sustainability and programs are to be acceptable and culturally competent.
They recognize that community-based health promotion must necessarily be part is participation and build on current community resources and skills.
The ecological levels of social capital.
Going to focus on the middle one.
Communities often refer to at the METSO level in social ecology.
Remember social trust including community trust in organizations and institutions, community participation, social norms and collective actions.

We'll see how these indicators of social capital are depressed in a case study of a community-based organization and program.
In our case, the efforts are directed towards HIV/AIDS but you can substitute any MCH problem or issue here.
What is important here is the community context or setting in which the problem is identified and addressed and the processes and resources that allow for that.
Role of community-based organizations.

Within the community, we focused on the role of community-based organizations because collaborative partnerships to improve community health typically involve one or more organizations.
We recognize this term is used broadly and so we mean community-based, not just community-placed.
The CBO's or community based organizations function as an expression of the will of the community.
They're mediating structures connecting local, social and organizational networks within the community and to the broader society.

They have moral authority by virtue of their history and record on improving the quality of life with consistency and integrity in the process reflecting the voice and experience of the community.
They are vehicles for mobilization and for dissemination, clarification of information and ideas.
So that social space for interaction and debate.
The importance of social capital.
There is some literature that relates social capital to health.
However, few articles address practical applications for improving community health.

Furthermore, the indicators used to date such as membership in associations and voting, for example, are often applied to middle class communities and do not capture the complexity or richness of other ethnic communities.
Case studies are needed to better understand the usefulness of social capital for health improvement.
Just to check in, we were just finishing slide 7.
Swapna will now talk about methods and the organization of interest to us.

SWAPNA SAWARDEKAR: Thank you.
Our methods are brought into the semistructure interviews as are dialogue and community -- the most crucial part of it is the effort taken to the accepted and known within the community.
An understanding of how it works we found it extremely important to be consistent and open about our research.
Dr. Kelly attended many community events and participated.
Much is learned about mutual cooperation and collaboration within the community and community leadership and values during this mutual encounters.
This information is extremely important to know before we would design a health promotion initiative.
We held an introductory workshop on qual Tateive methods that was well attended by the community and developed a relationship with the community over time that added to the value of her work and we'll talk about that later.
The procedures were that we had community involvement through conceptuallyization and analysis.

We provided manuals not only for the interviewers but also for the interviewees.
We respected the community's ability to think for itself and ask us questions.
We practiced a learning model meaning that everyone learns from each other.
In the slide we did the usual activities for a qualitative history.
But the participation involved much more than that.
One of the challenges of doing the research is the first would make the study total full of participation.
Yet we believed we could not get the quality of information we have without full participation.
So not only -- it also improves science.
We'll be talking about PRCC which is the Puerto Rican cultural center.
It is imbedded in the Puerto Rican cultural center.
It reflects the old style of San Juan.
It is conscious of itself.

The organizational values on the right are an expression of social norms which are also indicators of social capitals.
The English translation of the Spanish on the right-hand side at the bottom in code means that to live and health to live as opposed to live and let live.
This organization has many programs to improve the health and well-being of families and children such as an alternative high school, childcare center, family learning center.
But one of the major programs of this organization is life and aids.
The overall goals is primary prevention through community education.

This program was developed out of community social capital.
It continues to be a critical public health issue among the Puerto Rican population in the U.S. as well as in the islands.
As the health promotion initiative of the RCC the health prevention programs are targeted toward life experience.
Consider the program that means -- this is a metaphor for unity, strength and courage in the face of adversity.
This young woman's discussion group and discussion support group raises critical awareness, teaches life skills and enhances their sense of well-being.
The following slides will show how elements show how it sustains it.
I'll call about Jeannie to tell you about what we encountered through the interviews.

JEANNIE CONCHA: Thank you.
Through our qualitative analysis we looked at several interviews that Dr. Kelly conducted with many of the leaders and staff there at PRCC and we obtained so much information about the community, the members, the organization that was so useful but unfortunately we couldn't put all the great quotes we saw.
We selected a few that we felt basically represented what social capital means to the organization and how it is used and how it's reflected through the community.
And most of the information that we obtained through the interviews was basically about the organization as well as the community and how those are congruent or not.
Since we were working so collaboratively with the organization they gave us pictures that we felt would help kind of describe and show what the community is all about.
On the community participation slide if you notice on the left top corner there is a picture.
This is a health program within PRCC that was established in the early 1980's.

It's a community-driven program that was developed through students in the community and basically that was a response to the HIV/AIDS crisis in the early 1980's.
You'll notice in front that the muralls.
Murals within this community are everywhere.
They tend to use signs and Tim -- symbols to communicate.
Basically this community-driven effort is kind of -- sets the stage for a lot of the programs that are established in PRCC and the other program in the sense that when they create different programs they're always working and collaborating with the community and asking them for input and does this work for you.
If you notice the second quote, when they're developing programs for the youth, they go to them does this work for you and really encourage involvement and community participation.
And so this type of collective effort and action basically really helps in the development of good and meaningful programs, as well as social capital.

When we asked the interviewees about describing what their organizational characteristics were about, a lot of what we found was culture, they talked about their culture.
What it's like to be Puerto Rican, the history.
I learned so much about Puerto Rican history.
So culture was emphasized and how that is relayed in the community and basically when we talk about community-based organization, one of the quotes that I really liked is the second quote.
It's how you capture of the essence.

I am only to assume it's the heart of the commune -- community.
I think the quote ex -- through this understanding, since the organization knows a lot about the -- they're driven, it's a community driven organization, they know their history.
They identify a lot with the community and this identity kind of fosters trust and caring because they're able to show, I understand you.
I know where you're coming from.
I know your history.
I know your life experience.
They develop this trust with the community which really can enable the community to develop programs -- successful programs and programs that have meaning to them.

It's great because communities can really identify to this and kind of that leads to sustainability of programs.
We also asked the interviewees about community characteristics.
We gathered there was a really strong sense of community, sense of identity.
They constantly made comments and attributes to residents saying they really participated.
They knew each other.
They participated in the program events.
One quote they talk about working with the neighbors.

And there is a sense of social responsibility as well.
And I think the very cohesive bonds that create the community lend itself to social responsibility.
And unlike maybe a program that's kind of implemented within a community and not community driven I think there is that lack of understanding, that life experience, the history.
So many of the community characteristics it's very we owe each other.
Not only that, but they kind of work across different ethnic groups.

And within this community, they really made strong efforts to work with other ethnic groups as well as Mexicans, different Latino groups and Arabs and they worked really strong with them to kind of empower themselves across different issues.
So it wasn't just us as Puerto Ricans but we really want to share experiences across different ethnic groups creating the multi-cultural empowerment and sense of community.
We wanted to also capture how an organization, or this organization, impacts the community.
And our approach kind of leant itself to getting a sense of what they see.
One thing that kept coming up is trust.

There is obvious trust between the community and the organization.
And just through the conversations they had with us about working in the community, we kind of got the idea that they're always there.
There is no boundary about their work hours.
Some of the quotes, the first quote there, they know that although I work here, I'm also in the neighborhood.
The second quote, they know that I'll open the door up and give them condoms.
So there is this sense of consistency.
They know they're there, they live in the community, they can trust them.
After hours, before hours.

It's so funny because the interviewees would talk about how they carry condoms everywhere they go because in the grocery stores someone will stop them and say you're the condom man.
So it's just this understanding of who they are to the people and what they mean.
So as far as organizational impact just the fact that the community can really respond to them that way I think is awesome and great and I think that's what we should always look for is that sort of relationship that exists in a community.
So ultimately when we've considered all these ideas and concepts, I think that really leads to change in the community.
Regarding HIV/AIDS this seems to be a very important topic to the organization and, you know, they know they have to set the foundation, create a relationship, let's have you trust me.
And with those key characteristics of an organization, it really leads to facilitating the community to also participate in change.
It's not just one organizationing it's a community.

So any time there is an issue where they have to advocate for aids issues, they really have a strong pull with the community.
The community is always there.
They'll attend major community events and this is just by -- if you go to one, any time there is an event, a parade, the community is there.
So there is that trust.
And so it also allows them to form alliances.
If other organizations see how willing and how devoted they are to these issues, other organizations really take part.
And I guess the Democratic value expressed in that second highlighted quote, being visible and equal in the whole Democratic process but trying also to make the community see that, represents how well the social norms and expectancy contributes to increase community action.

And so the process of our analysis for this case study is based on assumptions of how knowledge is created.
In classic epidemiology there is an assumption that we can make observations, collect data and share understanding in a logical positive approach.
In this study, however, we drew upon another approach to inquiry where we looked at subjective meaning that is ascribed to life experiences that is not immediately apparent to the outside observer.
We really wanted to dig deep and know about these peoples' lives.
And the process that we used going back and forth to the community for obtaining additional data and to clarify meanings with the interviews.
If we didn't understand something, Dr. Kelly has a great relationship with the members out there.
They've adopted her as a Puerto Rican and I think which is awesome.
It's great.
It helps in implementing programs.

So she has that really strong relationship with them and can talk to them and speak with them are we getting this right?
Is this what you mean?
Which I think is crucial.
And so that is part of a participation research method and also called member checking in qualitative analysis for qualitative research.
To capture complex social phenomenon with large scale interviews is really difficult.
If you want to look at communities, implement community based programs at a MEZO and macro level you need to look at the different ethnic groups and understand their culture as well as experience it.
One of the things we don't see in the literature is self-reflection on the investigator's part.

I know for myself and I know Swapna and I have talked about as well as Dr. Kelly, understanding their history and their experiences really made us self-reflect about our history and our experiences and where we're coming from and where they're coming from and kind of like meeting.
We would be like yeah, we had that same experience, too.
Even though we're from different ethnic backwards we saw similarities as well as differences, which is great because we can really work with that.
I think it's crucial with working with and collaborating with communities.
OK.

MICHELE KELLEY: Preliminary findings.
To summarize the information obtained from the community, we've listed the dominant themes and this is all using a software called ATLAS TI.
The message is important.
These themes are currently under discussion with the community.
These have been previewed or I could not really present them today.
A full model showing the interrelationships among these concepts over time and how program issues get identified and programs that constructed from community has been drafted.
From what was shared today, we can see that cultural competency at the community level really means ecological validity.
That means the themes and programs are consistent and congruent with peoples' lives.
So that's competency at a program atic level.
The next slide continuing preliminary findings you can see the idea of cultural preservation and establishing services within a cultural and spiritual context really shows the uniqueness of a community-driven initiative.

It's something that could not be duplicated by me going in with a lot of expertise and trying to create something.
And the next slide on preliminary findings, number 20, it is important to recognize that communities have existing structures for developing strategies, solving problems and spaces for reflecting on critical issues.

They use a model, if any of you are familiar with that, it's very important, very Latin American derived and very effective.
Where people use their own reasoning processes and the community leader will really engage in cognitive restructuring or reframing of issues so that people can identify to the issue and say that's important to me.
Instead of just like throwing information at people.
So these structures were created and exist because of social capital.

They are invaluable resources in designing collaborative health promotion programs.
Conceptual model that displays the relationship among all these concepts will be available at our presentation at APHA.
It's in draft form and we're discussing it with the community.
So we really couldn't present it today.
And then it's important to think about all the limitations we encountered in these huge endeavor.
Right now we have one case study that has multiple sources of data in it.
We presented information from interviews.

Because of the nature of our inquiry, we did not focus on quantifiable aspects of social capital such as like assessing the prevalence of social trust in a community, or assessing social and organizational networks or counting the number of social settings for community discourse and interaction within a community.
A complimentary quantitative study would add to our knowledge of social capital in any given setting.
Similarly a longitudinal study about how community organization developed over time with yield a deeper level of understanding in the role of social capital.
Although we have some limitations, there are advantages as well.
As a student Swapna has developed a practicum in the community and she'll talk about the value added of this kind of engaged research.

SWAPNA SAWARDEKAR: Relationship with the community, always new opportunities have come up and we have taken advantage of them.
A community participating in the study is now a student of the school of public health which is a big accomplishment.
Also additional students have been recruited because of our presence in the community.
This year as well as last year we had a class meeting in the community where we learned the importance of sense of community and cultural identity.
I personally am involved with a field practicum at the alternative high school at the RCC and will be working with the school developing a health curriculum for the students there.
Additionally other students are planning a practicum at the RCC.
We have also developed a relationship with the University of Puerto Rico and are now working together to plan a youth health initiative in the community.
As you can see this is a value-added.
Not just to the community but to us as well.
Jeanne is going to talk about implications now.

JEANNIE CONCHA: Well, after analyzing and talking about all these issues we came up with some key questions that we felt were really important for any public health researcher and I'll go ahead and read these off.
I'm sure we'll find many others.
Basically what seems to be indicators of social capital in a particular community setting?
And can the community identify those indicators?
Consider how social capital concepts can be useful in program design and evaluation.
A lot of times we look at numbers and outcome numbers and I think the essence of what the community is lost and I think qualitative can contribute to that.
How can community trust make a difference in program outcomes or in broader change for community health?

So basically through our qualitative research and trying to figure out what social capital means to the community and how they use it, we've basically found some great themes and basically new understandings about their shared history, culture, signs and symbols used within the community, trust, all those issues really contribute to establishing a program that has meaning to the community.

I think that's really important because if it has meaning, I think sustainability of that program will just last.
And I think the strength -- I think most important is really looking at the strengths of the community and the assets that exist and how and what they mean can only contribute to us developing programs that have meaning and that can be maintained after researchers leave for -- if funding is ended it is nice to kind of have something that can hold a program in a community for a while and I think we'll see this as a good example.
This started in 1983, got institutionized within the community and funded through CDC and so I think we just have to work with those issues and I think, you know, Michele, you want to take over?

MICHELE KELLEY: Thanks.
So we hope you can see the connection here between what we really humbly presented in a short period of time.
Very complex social phenomena.
In working with critical MCH issues in the community.
I think you could substitute any topic for HIV in there.
Hopefully we can see somebody watching at our APHA presentation this fall and the information is on this slide.
We will be presenting the full concept tue all model of social capital and the community's response to a critical public health issues, HIV/AIDS.
Our community partners will also be there.
The contact information is up there and please feel free to email him if you have questions for the community.
Normally we try to have, you know, a community member co-present with us.
That will happen at APHA.

I want to thank everyone at the program and the community at large for their generosity in working with us.
And then I guess lastly on the very last slide we have three of what we thought were some of the better references for community-based public health promotion and public health research that tie social capital to the utility of social capital for those concepts.
And once again thanks again for giving us the opportunity to present and in joining us today.

LAURA KAVANAGH: Thank you very much.
Enjoyed your presentations.
Now it's time for questions and answers before we sign off for the afternoon.
Turn it over.

MADHAVI REDDY: I think Dr. Ryan had a question for people in Chicago.
You can ask your questions to Michele.

SHERYL RYAN: I'm assuming that all of you spoke Spanish with the -- I would like to ask the question, did you speak Spanish or did your interviewers speak Spanish, was that needed?
Did that help in terms of being able to communicate with some of the members of the community?

MICHELE KELLEY: Actually that's a very good question.
I mean, my Spanish is not that good.
I can -- because of the graciousness of people I can make myself understood and get around.
I could get around in a Spanish speaking community but not good enough to communicate with people in an interview like this.

So let me tell you the interviews were conducted in English.
In this particular community in Chicago, the younger generation speaks English and the older generation can speak Spanish or Spanish and English.
And they want more the younger people to learn their language, the Spanish.
So Spanish is -- English is the first language for some of the young people and then at the program at the high school they are mostly in English.

So there was one interview, though, where I was speaking with a young man who really could have -- I know he could have expressed himself better in his first language and that interview was done in English.
In other communities we have done interviews in Spanish with very competent interviewers and for the science purpose in the software we have it does allow for you to hyper link the Spanish to the English translation.
So that one can get support and get back to that original language if you use Spanish.
So in some cases it wasn't necessary, but in one case that I know of it would have enhanced the quality of the data to have it in Spanish but it was done in English.

LAURA KAVANAGH: Thank you.

MADHAVI REDDY: We have another question for Michele, Swapna and Jeannie.
What has the reaction been from the Puerto Rican community at large to such a progressive organization focused on sexual health?
If the community has been receptive, what do you attribute the success in broaching such an issue on a broad level.

MICHELE KELLEY: You know, this is where I really wish someone was here to give a more authentic representation.
I've been working with this community for about at least three or four years and I was introduced to them by a community partner in another project that we did on social networks and pre-natal care.
All the time I've just been very impressed with how the community articulates issues in a way that they can find a comfort zone for people.
The reason that they named their agency what they did is to put the word life next to Aids.
Certainly they're not saying it's a good thing to have Aids.
They don't want to scare people.
They said that a lot to us.
That we don't want to go out, if you just say Aids you will scare people.

They make it their business to get -- in Jeanne's presentation to get into all the spheres of life in the community.
In the business sector if there are community celebrations or festivals they're there.
Not only for the HIV prevention people but they help set it up.
They'll take a broom and sweep the sidewalks in front of businesses.
I joined them in one activity just to sort of get a feel of, you know, what it's like and how do they organize to do that.
They get involved in all the spheres of life in that neighborhood.
So they -- people are comfortable with the folks working there.
They are from the community.
There may be, as in every community, is not monolithic and there may be some people that maybe they wish they weren't there.
I've never heard that.
I've never seen it.
I've only seen praise for that organization.

I know they do have their political representatives behind them.
They're very well organized and I think one of the most important things is that they articulate their issues very well.

Congruent with how the community expresses itself.
You couldn't see it well in one of the photos, there is a beautiful mural that was done.
The students at the high school designed it and so everybody knew that this is -- our kids designed this.
And that means a lot, too.
It wasn't just somebody coming in and let's have an outsider do this.

JEANNIE CONCHA: I think Michelle had made a comment earlier about how they can create social norms and I think the one thing I was really impressed with is the use of signs and symbols create a norm.
It's OK without putting it in someone's face.
Any advertisements that are developed within the community, there is always, you know, a little thing about HIV/AIDS and even with the youth they are always working with the youth to talk about the issue.
Through art, especially through art.
What does it mean to them.
So it's this subtle, implicit way.

MICHELE KELLEY: There is a song rap, community theater, different venues that they have.
You know, the message can be abstinence, too, you know?
And when parents in the community, they know there is very dense network which is important to know.
So people know that their niece or daughter is somebody is presenting or doing something, they come and have fun and celebrate their culture.
They eat the foods, they listen to music.
You may think these youth are just interested in an art class or a mural or creating a CD.
But before you know it, they're learning about risk for HIV and how to, you know, in language by which they can negotiate relationship issues.
So I think everything is sort of embedded in this cultural kind of context and community celebrations sometimes.

MADHAVI REDDY: This is a question in reference to Dr. Kodjo's presentation in reference to her search for a fund to continue her research.
We got a question.
It's something that the division might be able to answer.
Developing a research program to develop first or R21 like awards or other mechanisms to help new investigators make transitions to independent funding, especially for work that meets the needs of HRSA wide programs and priorities.

LAURA KAVANAGH: Do you want me to start and then--

CHERYL KODJO: Sure.

LAURA KAVANAGH: This is something that we've been interested in.
We've done additional work at the bureau to develop dissertation awards for doctoral students to conduct research to help the transition into research.
One of the other ideas that we explored was support for junior faculty members in initiating a research career path in Maternal and Child health as well.
Unfortunately with this new HRSA preview, the dissertation awards and the research capacity grants will not be competed this year.
So we're hoping that sometime in the future we'll have additional funds available but we're certainly interested in exploring those opportunities.
We just are looking at flat funding in the next year as far as we can tell so far.

CHERYL KODJO: Thank you.
I appreciate your comments.
It's so funny that you mention this as an issue because I'm just coming off of a conference that was sponsored by the AAMC regarding minority faculty development.
Certainly the issue with funding was key and where to be able to look for resources.

I certainly will be keeping a wide scope in mind to see where my particular research questions best fit the priorities of an agency.

MADHAVI REDDY: I think this question might be for Dr. van Dyck.
But if you might want to tackle it.
I can go get him afterwards.
A question came in, I think Dr. van Dyck mentioned that some of the EMS and hearing screening programs would be absorbed in the block grant.

LAURA KAVANAGH: That's the intent of Congress.

MADHAVI REDDY: This question is, wouldn't this absorption into block grants cause internal competition in prioritizing a healthcare programs causing need and care?

LAURA KAVANAGH: Causing metered care?
Yes, it will increase competition.
It was not the intent of the -- I don't think it would be a position that the bureau would hope that they would continue to be funded as EMS and newborn hearing screening programs.
It was the intent of Congress that they provided the startup funds as separate funding streams in emergency medical services for children and newborn hearing screening and thought it should be absorbed in the Title V block grant.
If that comes to fruition it will increase competition for those Title V block grant dollars, absolutely.

MADHAVI REDDY: OK, great.
One other question for Dr. Kelly and company in Chicago.
For the program representatives how is social capital harnessed for communities without existing community health organizations?

MICHELE KELLEY: You know, we actually have that in our little model that I can't show you.
It's kind of like -- that's a very complicated question.
It's kind of like social capital is sort of like this starter dough.
A chicken, egg question.
Communities as they form themselves over time, some leadership emerges and that leadership exerts influence on the community in terms of what -- they have to form an identity and have a self-consciousness about themselves and that kind of gets projected in -- you know, you walk down a street, you can get a feel for what kind of community you're in.
And some communities it's very clear that there is a particular identity there by the kinds of religious institutions, the kinds of grocery stores, the way the store fronts look, things like that.
Newspapers.

Their own media or vehicles for disseminating information and networks and forming networks.
And I think that one has to just go in and look to see what is in place there.
That's really an assessment of how the community is socially organized.
First usually you begin to see these institutions occur.
I mean, in the community of psychology literature is the best place to look and some in urban planning.
One of the first things to develop are religious institutions and grocery stores and new emerging ethnic communities.
Those may be places to start if they're locally owned and operated, depending on how the leadership feels and having dialogue with people about what their critical health issues are and sharing the data we might have with them if it matches what their experiences are.

There may not be, as in this case, this organization, you know, the cultural center that has sprung up and developed its own programs as they saw the need.
But over time I think that you would see that.

It's an evolutionary process depending on, again, the leadership in the community and how long the community has a presence there.
I kind of look for expressions of that self-consciousness and if -- and sometimes we do have faith-based initiatives.
I think it's that recognition that sometimes it's religious institutions that may be the ones to work with in that community.
We aren't saying one or the other.
But in this case we had a case study there was an institution formed that was expressing the will of the critical mass of the people connected to the political leadership and very accepted by the community.

So that, you know, that is a vehicle for a good partnership to form, I think, if the intentions are good on both sides and with trust and a lot of dialogue.
I mean, I hung -- I hang out there in that community because I want to because I learn a lot every time I go out there.
I've spent many Saturday afternoons out there just talking to people, sitting in a cafe that is a gathering place.
That's how I get to know about those things.
But I think that even in the absence of like a 501C3 organization you can look for other signs.
Just by asking people, too, we can ask, you know, how do things get done in this neighborhood?
Who accomplishes things?
What are you recently proud of?
What did the community accomplish?
Who is behind getting that done?
If you ask a few people similar names will begin to come up repeatedly.

And that's the person I want to talk to if I want to have a dialogue with that community about a partnership.
So it may be a less formal structure institution.
But there is usually something there.
I hope that helps.

LAURA KAVANAGH: Thank you very much.
Thank you very much to our presenters.
Thank you for all of those who were able to participate in the MCH webcast today.
Please take a moment to fill out the evaluation form and you'll be hearing from us shortly about the next webcast in the near future.
Thank you very much.
Good afternoon.